The Indiana Family and Social Services Administration

Division of Disability and Rehabilitative Services (DDRS)
Home and Community Based Services (HCBS)
Waiver Providers

Provider Re-Approval Webinar

September 20, 2016

Shelly Thomas, Assistant Director
Bureau of Quality Improvement Services (BQIS)






AGENDA

- Evolution of Re-Approval Process and Process Modifications
- Process Flow
- Changes to the Re-Approval Assessment and Documentation
- The best way to analyze your organization's data
- Helpful Tips on Submission of Documents and Process Flow
- Resources

Evolution of the Re-Approval Process

Challenges that needed to be addressed:

- Restricted time frame for providers to complete the re-approval process
- Reports and forms were complex and difficult to view due to the format

Modifications to process to ensure:

- Collaborative Approach
- Well Defined Processes
- Document Clarity
- Meaningful data review
- Improved outcomes for consumers

Step 1 - December 2014

- Provider submission of Re-approval Assessment changed from 10 calendar days to 30 calendar days
- Provider submission of Addendum(s) changed from 2 calendar days to 10 calendar days
- Questions added to the Re-Approval Assessment to help guide provider's responses.

Step 2 – Lessons learned in the first quarter 2015….. April 2015

- Data Assessment changed from essay style responses to a question and answer format.
  - Document renamed **Re-Approval Assessment.**
- Provider communications updated to add clarity.
- Requirement for providers to submit Accreditation documents added to insure BDDS data is current.

Step 3 – Lessons learned from April 2015…..to present

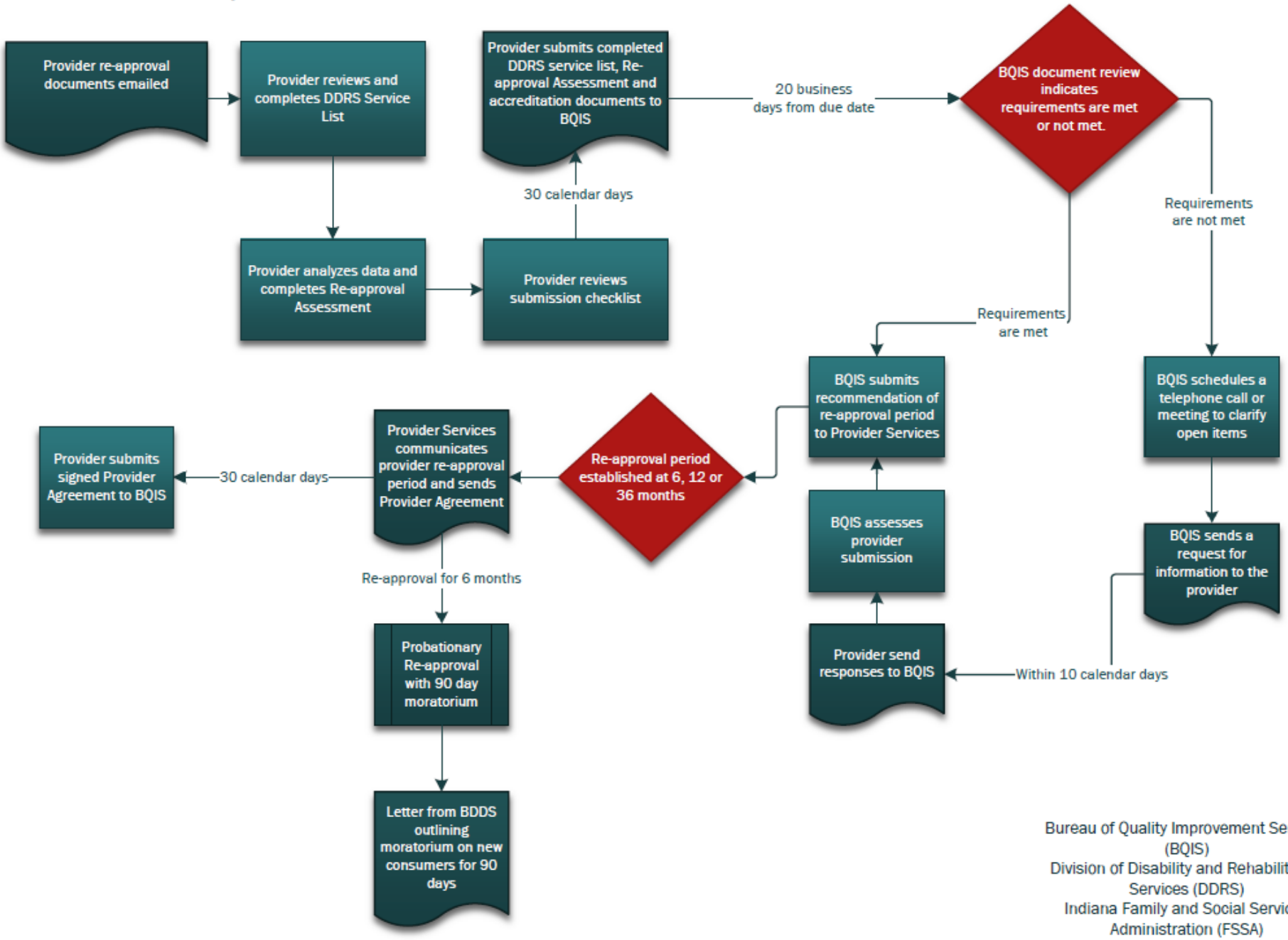
- Re-Approval Assessment questions were revamped to add clarity and remove redundancy**.**
- Requirement for providers to review and update DDRS service list and submit with re-approval.
- Inclusion of a submission checklist to assist providers in the process.

Looking ahead to the future:

The HCBS Waiver Services Provider Re-Approval Toolkit

- Step-by-step instructions and guidance regarding overall re-approval process
- Data analysis guidance
- Tools to assist with the re-approval process
- Outline evaluation methodology for determining length of provider re-approval

Provider Reapproval Process Flow
March 2016



Bureau of Quality Improvement Services (BQIS)
Division of Disability and Rehabilitative Services (DDRS)
Indiana Family and Social Services Administration (FSSA)

Provider Re-Approval documents emailed

- Initial Letter
- DDRS Service List – Currently Approved
- Re-Approval Completion Guide
- Summary of Provider Review Profile (PRP)
- PRP – Full Report
- Excel Spreadsheet of Incident Reports for Specified Timeframe
- Re-Approval Assessment
- Submission Checklist

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

Via Electronic mail

DATE

[CONTACT INDIVIDUAL]
[CONTACT INDIVIDUAL TITLE]
[PROVIDER NAME]
[PROVIDER ADDRESS]
[PROVIDER ADDRESS]
[PROVIDER EMAIL ADDRESS]

Re: Provider Re-Approval

Dear **[CONTACT INDIVIDUAL]**,

The Bureau of Quality Improvement Services (BQIS) within the Division of Disability and Rehabilitative Services (DDRS) facilitates the re-approval process for DDRS-approved waiver providers. During the ninety (90) day window prior to the expiration of the current approval period, providers of supported living services or supports are required to renew their status as an approved provider as outlined in 460 IAC 6-6-5. At this time, your organization is due for re-approval.

The re-approval process has been designed to facilitate discussion and review performance-based data. The following attachments are included with this letter:

Attachment A	DDRS Service List – Currently Approved
Attachment B	Re-Approval Completion Guide
Attachment C	Summary of Provider Review Profile (PRP)
Attachment D	Provider Review Profile (PRP) – Full Report
Attachment E	Excel Spreadsheet of Incident Reports for Specified Timeframe
Attachment F	Re-Approval Assessment
Attachment G	Submission Checklist

A list of currently approved DDRS services (Attachment A) is included for review and the updating of information that might be inaccurate. The Submission Checklist (Attachment G) contains complete instructions on updating and returning the DDRS Service List.

During the re-approval process, providers are asked to articulate the systems (e.g. policies, procedures, protocol, etc.) that exist, as required by 460 IAC Article 6, and how their policies, procedures, and protocols were implemented in a consistent manner, ensuring the health, safety, and welfare of the individuals they serve. Additionally, the providers will explain their specific processes for identifying problems when they occur and the procedures utilized in addressing those problems. The Re-Approval Completion Guide (Attachment B) contains information that will assist your organization in completing and submitting the required information for re-approval.

The Provider Review Profile (PRP) (Attachment D) is a detailed data-driven report specific to your organization consisting of information from complaints and incident reports. For first time re-approvals, this also includes data from the compliance evaluation review tool (CERT). The PRP is structured to provide a comparison in multiple risk areas. A summary of this information is provided in Attachment C. The PRP allows the provider to assess their organization's data against a benchmark of relatively similar providers (e.g. client count, Algo levels). The analysis of this data is pivotal in reviewing your organization's performance. An Excel Spreadsheet (Attachment E) containing all incident reports included in the PRP is attached to support your organization in the analysis of its data.

Following review of the PRP, the Re-Approval Assessment (Attachment F) must be completed by the provider. Providers are asked a series of questions, by category, to assess how performance is monitored and how service level improvements are made based on the data. Additional questions are focused on the broader subject of providing quality care and services, including how the organization will implement changes and what corrections are necessary to achieve the desired results.

As part of the re-approval process, providers offering services that require national accreditation are required to submit the most current accreditation documentation. Indiana Code (IC 12-11-1.1-1(d) (j)) requires the following DDRS waiver program services to be nationally accredited:

- Day Services (including Adult Day Services)
- Community Habilitation
- Facility Habilitation
- Pre-vocational
- Residential Habilitation
- Extended Services

On or before **[DATE 30 CALENDAR DAYS AFTER THIS LETTER]** please submit all documents listed on the Submission Checklist (Attachment G) to BQIS at BQISReporting@fssa.in.gov.

Once submitted, BQIS will review the completed Re-Approval Assessment and will contact you on or before **[DATE 50 BUSINESS DAYS AFTER THE PROVIDER'S DUE DATE (=workdays(ProvDueDate,20)]**. Providers may be asked to meet in person or via telephone for the purpose of BQIS explaining any clarifying questions that require further explanation/detail by the provider. The provider through the submission of a re-approval addendum will submit the clarifying information. BQIS will then make a recommendation to Provider Services to re-approve **[PROVIDER'S NAME]** for 6, 12, or 36 months. Provider Services will notify your organization of its re-approval period.

Additional information regarding provider re-approval is available on the Provider Services webpage (www.in.gov/fssa/ddrs/2644.htm). Thank you for your cooperation in this process. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Shelly Thomas
Assistant Director
Bureau of Quality Improvement Services
402 W. Washington St.
Indianapolis, IN 46204
(317) 234-2764
Shelly.Thomas@fssa.in.gov

Attachments

PROVIDER RE-APPROVAL COMPLETION GUIDE

PROVIDER RE-APPROVAL

The provider re-approval process is designed to validate that a provider maintains policies, procedures and systems that ensure the needs of consumers are met according to Individualized Support Plans, Behavioral Support Plans and Risk Plans. Providers must substantiate that their systems (i.e., policies, procedures, protocols, staff training, etc.), are designed to address quality improvement and all processes are aligned to offer programs with health, safety and welfare at their core. The Bureau of Quality Improvement Services (BQIS) will utilize Provider Review Profile data, the completed Re-Approval Assessment, and any requested addenda to justify a recommendation of a re-approval term of 6, 12, or 36 months.

DOCUMENTS

To perform a thorough fact based review, a provider-specific report has been developed and is titled the **Provider Review Profile (PRP)** (Attachment D). Once the provider has reviewed and analyzed its PRP, the provider then completes the **Re-Approval Assessment** (Attachment F) document.

PROVIDER REVIEW PROFILE (PRP) – ATTACHMENT D

The PRP is a data-driven report that allows the provider to assess its organization's data against a benchmark of relatively similar providers (e.g. client count, Algo levels). Analyzing this data is pivotal in reviewing the provider's performance. The PRP is structured to provide data in multiple risk areas.

The first page of the PRP is a worksheet which contains the raw data for the provider. The next section contains risk area data which includes complaints, general incident data, incident processing data, data for abuse, neglect and exploitation, behavioral data, and medical data. The final section of the PRP is a technical guide that includes the calculations for each of the risk areas. For each of the risk areas, the provider should analyze the raw data to determine one or more reasons for being out of the expected range (above or below). Attachment E in the re-approval documents is an Excel spreadsheet of all incident reports for the timeframe in the PRP. This data should be an essential tool in conducting the data analysis.

RE-APPROVAL ASSESSMENT – ATTACHMENT F

The Re-Approval Assessment is designed to detail the data analysis conducted, convey organizational processes, demonstrate compliance, and identify areas of improvement. There are six sections. The first four sections are linked to the risk areas in the PRP: complaints and incident data; incident processing and ANE data; behavioral data; and medication and medical data.

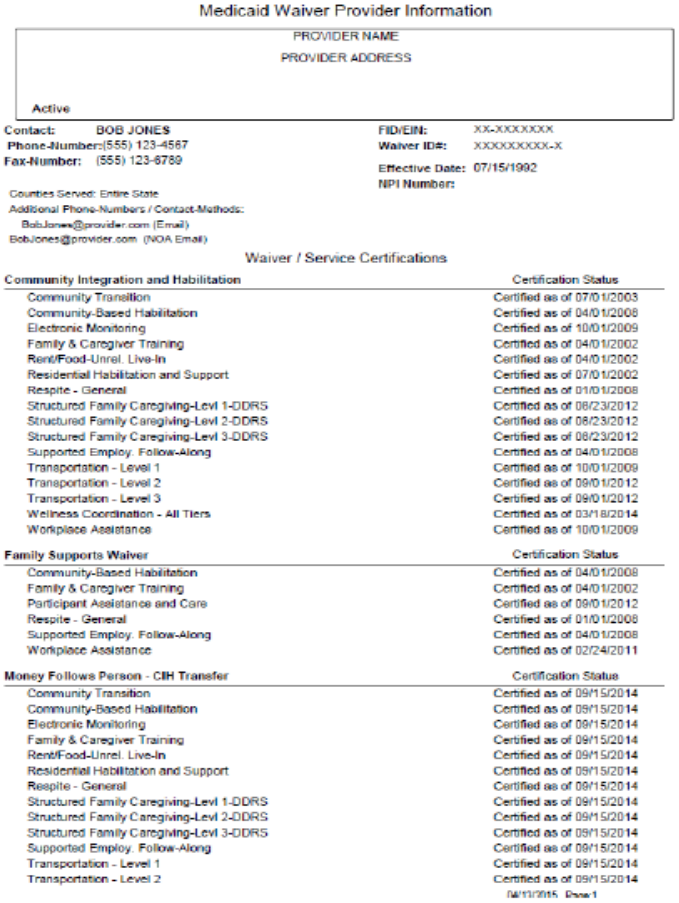
For each risk area identified as above or below the expected range, the provider will explain the reason for being out of expected range. Data that falls *below the expected range* or *above the expected range* may be indicative of issues within your organization's operational systems. Data that is above or below that of your peer group is not where an organization's data should fall and requires a full analysis of the data to explain the results. A review of the data with a quantitative analysis may provide the information to assist in determining the root cause. The results of this analysis are documented on the Re-Approval Assessment. For the re-approval process, providers should consider how their respective PRP data is reflective of quantitative and qualitative data: quantitative numbers are indicative of measureable facts, but the qualitative data is suggestive of what methods your organization uses, and whether or not they are working to deliver outcomes, your organization expects.

Tips: When documenting the reasons for the variation from the norm (being above or below the expected range), consider issues such as individual-specific data that may be affecting your rates (e.g., repeat incidents attributed to a few consumers). Detail if there is evidence to suggest data is trending in the right direction (i.e., showing improvement).

Once the data has been analyzed, the provider is asked a series of questions to assess how performance in these categories is monitored and how service level improvements are made based on the data. The remaining two sections of the Re-Approval Assessment are focused on the broader subject of providing quality care and services.

DOCUMENT SUBMISSION

The completed Re-Approval Assessment is due on or before the due date noted on the cover page and must be submitted electronically to BQIS at BQISReporting@fssa.in.gov. When submitting this document, the provider may also attach to the email (as separate documents and labeled as exhibits) copies of supporting documents that will aid in the review of the provider's systems and processes; **however, these do not take the place of responding to the Re-approval Assessment questions**. All supporting documents must be referenced as exhibits within the Re-Approval Assessment. Once submitted, BQIS will review the completed Re-Approval Assessment. Providers may be asked to meet in person or via telephone for the purpose of BQIS explaining any clarifying questions that require further explanation/detail by the provider. The provider through the submission of a re-approval addendum will submit the clarifying information. *Note: Failure to submit a written Re-Approval Assessment by the established due date will eliminate the opportunity for provider clarification. Additionally, it may result in the provider receiving a re-approval term that is not preferred and/or a referral to the DDRS Sanctions Committee.*



Medicaid Waiver Provider Information

PROVIDER NAME

PROVIDER ADDRESS

Active

Contact: BOB JONES
Phone-Number: (555) 123-4567
Fax-Number: (555) 123-6789

FID/EIN: XX-XXXXXXX
Waiver ID#: XXXXXXXXX-X
Effective Date: 07/15/1992
NPI Number:

Counties Served: Entire State
Additional Phone-Numbers / Contact-Methods:
BobJones@provider.com (Email)
BobJones@provider.com (NOA Email)

Waiver / Service Certifications

Community Integration and Habilitation	Certification Status
Community Transition	Certified as of 07/01/2003
Community-Based Habilitation	Certified as of 04/01/2008
Electronic Monitoring	Certified as of 10/01/2009
Family & Caregiver Training	Certified as of 04/01/2002
Rent/Food-Unrel. Live-In	Certified as of 04/01/2002
Residential Habilitation and Support	Certified as of 07/01/2002
Respite - General	Certified as of 01/01/2008
Structured Family Caregiving-Levl 1-DDRS	Certified as of 08/23/2012
Structured Family Caregiving-Levl 2-DDRS	Certified as of 08/23/2012
Structured Family Caregiving-Levl 3-DDRS	Certified as of 08/23/2012
Supported Employ. Follow-Along	Certified as of 04/01/2008
Transportation - Level 1	Certified as of 10/01/2009
Transportation - Level 2	Certified as of 09/01/2012
Transportation - Level 3	Certified as of 09/01/2012
Wellness Coordination - All Tiers	Certified as of 03/18/2014
Workplace Assistance	Certified as of 10/01/2009

Family Supports Waiver	Certification Status
Community-Based Habilitation	Certified as of 04/01/2008
Family & Caregiver Training	Certified as of 04/01/2002
Participant Assistance and Care	Certified as of 09/01/2012
Respite - General	Certified as of 01/01/2008
Supported Employ. Follow-Along	Certified as of 04/01/2008
Workplace Assistance	Certified as of 02/24/2011

Money Follows Person - CIH Transfer	Certification Status
Community Transition	Certified as of 09/15/2014
Community-Based Habilitation	Certified as of 09/15/2014
Electronic Monitoring	Certified as of 09/15/2014
Family & Caregiver Training	Certified as of 09/15/2014
Rent/Food-Unrel. Live-In	Certified as of 09/15/2014
Residential Habilitation and Support	Certified as of 09/15/2014
Respite - General	Certified as of 09/15/2014
Structured Family Caregiving-Levl 1-DDRS	Certified as of 09/15/2014
Structured Family Caregiving-Levl 2-DDRS	Certified as of 09/15/2014
Structured Family Caregiving-Levl 3-DDRS	Certified as of 09/15/2014
Supported Employ. Follow-Along	Certified as of 09/15/2014
Transportation - Level 1	Certified as of 09/15/2014
Transportation - Level 2	Certified as of 09/15/2014

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Attachment A

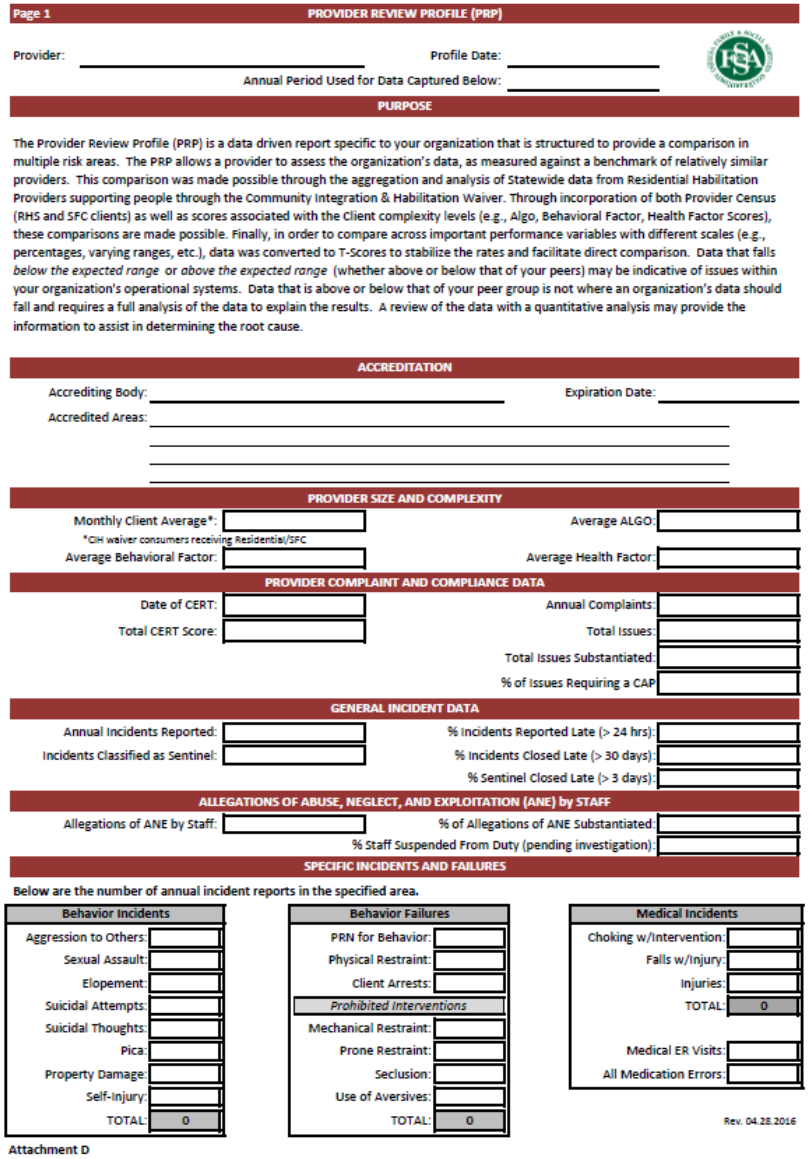
Summary of Provider Review Profile (PRP) Data

The table below indicates **[PROVIDER NAME]**'s data as measured against a benchmark of relatively similar providers (e.g. client count, Algo levels) in each risk category.

- Data in the *Expected Range* column indicates your organization operates comparably to its peers in the risk categories listed. Data reflected in these risk areas may be indicative that your organization's operational systems are operating as designed.
- Data in the *Below the Expected Range* or *Above the Expected Range* columns indicates your organization **does not** operate comparably to its peers in the risk categories listed. Data reflected in these risk areas may be indicative of issues within your organization's operational systems.

Section I - PRP Complaints and Incidents Data (Risk Areas include: Complaints, Complaint Issues Substantiated, % Issues Requiring a CAP, CERT, Incidents, Sentinel Incidents, % of Incidents Made Sentinel, Behavioral Incidents, and Medical Incidents)			
Below the Expected Range	***Expected Range***	***Above the Expected Range***	***N/A***
Section II - PRP Incident Processing and Abuse/Neglect/Exploitation Data (Risk Areas include: Incidents Reported Late, Incidents Closed Late, Sentinels Closed Late, Allegations of ANE by Staff, % ANE Substantiated, and % Staff Suspended from Duty)			
Below the Expected Range	***Expected Range***	***Above the Expected Range***	***N/A***
Section III - PRP Behavioral Data (Risk Areas include: Aggression, Sexual Assaults, Elopements, Suicide Attempts, Suicidal Thoughts/Ideations, Pica, Property Destruction, Self-Injurious Behaviors, PRN for Behaviors, Physical Restraints, Arrests, and Prohibited Interventions)			
Below the Expected Range	***Expected Range***	***Above the Expected Range***	***N/A***
Section IV - PRP Medication and Medical Data (Risk Areas include: Medication Errors, Choking w/ Intervention, Falls w/ Injury, Injuries, and Medical ER Visits)			
Below the Expected Range	***Expected Range***	***Above the Expected Range***	***N/A***

Attachment C



Page 1 — PROVIDER REVIEW PROFILE (PRP)

Provider: _____ Profile Date: _____

Annual Period Used for Data Captured Below: _____

PURPOSE

The Provider Review Profile (PRP) is a data driven report specific to your organization that is structured to provide a comparison in multiple risk areas. The PRP allows a provider to assess the organization's data, as measured against a benchmark of relatively similar providers. This comparison was made possible through the aggregation and analysis of Statewide data from Residential Habilitation Providers supporting people through the Community Integration & Habilitation Waiver. Through incorporation of both Provider Census (RHS and SFC clients) as well as scores associated with the Client complexity levels (e.g., Algo, Behavioral Factor, Health Factor Scores), these comparisons are made possible. Finally, in order to compare across important performance variables with different scales (e.g., percentages, varying ranges, etc.), data was converted to T-Scores to stabilize the rates and facilitate direct comparison. Data that falls *below the expected range* or *above the expected range* (whether above or below that of your peers) may be indicative of issues within your organization's operational systems. Data that is above or below that of your peer group is not where an organization's data should fall and requires a full analysis of the data to explain the results. A review of the data with a quantitative analysis may provide the information to assist in determining the root cause.

ACCREDITATION

Accrediting Body: _____ Expiration Date: _____

Accredited Areas: _____

PROVIDER SIZE AND COMPLEXITY

Monthly Client Average*: _____ Average ALGO: _____

*CIH waiver consumers receiving Residential/SFC

Average Behavioral Factor: _____ Average Health Factor: _____

PROVIDER COMPLAINT AND COMPLIANCE DATA

Date of CERT: _____ Annual Complaints: _____

Total CERT Score: _____ Total Issues: _____

Total Issues Substantiated: _____

% of Issues Requiring a CAP _____

GENERAL INCIDENT DATA

Annual Incidents Reported: _____ % Incidents Reported Late (> 24 hrs): _____

Incidents Classified as Sentinel: _____ % Incidents Closed Late (> 30 days): _____

% Sentinel Closed Late (> 3 days): _____

ALLEGATIONS OF ABUSE, NEGLECT, AND EXPLOITATION (ANE) by STAFF

Allegations of ANE by Staff: _____ % of Allegations of ANE Substantiated: _____

% Staff Suspended From Duty (pending investigation): _____

SPECIFIC INCIDENTS AND FAILURES

Below are the number of annual incident reports in the specified area.

Behavior Incidents		Behavior Failures		Medical Incidents	
Aggression to Others:		PRN for Behavior:		Choking w/Intervention:	
Sexual Assault:		Physical Restraint:		Falls w/Injury:	
Elopement:		Client Arrests:		Injuries:	
Suicidal Attempts:		*Prohibited Interventions*		TOTAL:	0
Suicidal Thoughts:		Mechanical Restraint:			
Pica:		Prone Restraint:		Medical ER Visits:	
Property Damage:		Seclusion:		All Medication Errors:	
Self-Injury:		Use of Aversives:			
TOTAL:	0	TOTAL:	0		

Rev. 04.28.2016

Attachment D

Page 2 — **Section I - PRP Complaints and Incident Data**

Provider: 0 Profile Date: 1/0/1900

		COMPLAINTS			INCIDENT DATA						
		Complaints	Complaint Issues Substantiated	% Issues Requiring a CAP	Incidents	Sentinel Incidents	% of Incidents Made Sentinel	Behavioral Incidents	Behavioral Failures	Medical Incidents	
	Provider's Rate	#DIV/0!	#DIV/0!	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
	T-Score										T-Score
Critical Risk	> 74	> 30.4	> 41.3	-	> 2.733	> 0.385	> 30%	> 0.701	> 0.507	> 0.433	> 74
	74	-	-	-	2.462 - 2.733	0.385	-	0.670 - 0.700	-	0.414 - 0.433	74
	73	20.3 - 30.4	34.2 - 41.3	-	-	-	30%	0.633 - 0.669	-	0.408 - 0.413	73
	72	-	-	-	2.347 - 2.461	0.358 - 0.384	-	-	-	-	72
	71	-	31.9 - 34.1	-	-	0.351 - 0.357	29%	0.617 - 0.632	-	-	71
High Risk	70	18.2 - 20.2	-	-	2.253 - 2.346	0.337 - 0.350	28%	0.599 - 0.616	-	0.367 - 0.407	70
	69	-	-	-	2.191 - 2.252	-	26-27%	-	-	-	69
	68	16.3 - 18.1	-	-	2.121 - 2.190	0.320 - 0.336	-	0.558 - 0.598	-	-	68
	67	-	-	-	2.071 - 2.120	-	-	0.542 - 0.557	-	0.341 - 0.366	67
	66	15.0 - 16.2	-	-	1.975 - 2.070	0.301 - 0.319	25%	-	0.333 - 0.507	0.324 - 0.340	66
Moderate Risk	65	-	24.5 - 31.8	-	-	0.289 - 0.300	-	0.510 - 0.541	-	-	65
	64	13.5 - 14.9	-	-	1.871 - 1.974	-	23-24%	0.480 - 0.509	-	0.303 - 0.323	64
	63	-	-	100%	1.803 - 1.870	0.265 - 0.288	-	0.460 - 0.479	0.287 - 0.332	0.296 - 0.302	63
	62	12.5 - 13.4	21.5 - 24.4	83% - 99%	1.744 - 1.802	0.264	22%	0.454 - 0.459	-	0.281 - 0.295	62
	61	-	-	80% - 82%	1.684 - 1.743	0.252 - 0.263	-	0.424 - 0.453	-	-	61
Low Risk	60	10.8 - 12.4	-	-	1.613 - 1.683	0.239 - 0.251	20% - 21%	0.420 - 0.423	-	0.256 - 0.280	60
	59	10.1 - 10.7	17.3 - 21.4	75% - 79%	-	0.224 - 0.238	-	0.395 - 0.419	-	0.250 - 0.255	59
	58	8.9 - 10.0	-	69% - 74%	1.519 - 1.612	0.218 - 0.223	19%	0.364 - 0.394	-	0.240 - 0.249	58
	57	8.5 - 8.8	-	-	1.440 - 1.518	0.204 - 0.217	18%	0.345 - 0.363	0.192 - 0.286	0.226 - 0.239	57
	56	-	14.6 - 17.2	63% - 68%	1.387 - 1.339	0.194 - 0.203	-	0.327 - 0.344	0.175 - 0.191	0.213 - 0.225	56
Expected Range	55	7.2 - 8.4	-	60% - 62%	1.317 - 1.386	0.184 - 0.193	17%	0.320 - 0.326	0.160 - 0.174	0.205 - 0.212	55
	54	6.0 - 7.1	12.5 - 14.5	56% - 59%	1.296 - 1.316	0.174 - 0.183	16%	0.288 - 0.319	0.138 - 0.159	0.191 - 0.204	54
	53	5.2 - 5.9	10.8 - 12.4	53% - 55%	1.186 - 1.295	0.163 - 0.173	-	0.282 - 0.287	0.121 - 0.137	0.182 - 0.190	53
	52	4.7 - 5.1	9.3 - 10.7	48% - 52%	1.128 - 1.185	0.152 - 0.162	15%	0.250 - 0.281	0.105 - 0.120	0.172 - 0.181	52
	51	4.1 - 4.6	-	46% - 47%	1.082 - 1.127	0.143 - 0.151	14%	0.234 - 0.249	0.092 - 0.104	0.157 - 0.171	51
	50	3.2 - 4.0	7.1 - 9.2	41% - 45%	1.010 - 1.081	0.133 - 0.142	13%	0.217 - 0.233	0.073 - 0.091	0.147 - 0.156	50
	49	2.5 - 3.1	5.7 - 7.0	-	0.957 - 1.009	0.121 - 0.132	-	0.194 - 0.216	0.065 - 0.072	0.136 - 0.146	49
	48	1.6 - 2.4	4.8 - 5.6	36% - 40%	0.887 - 0.956	0.112 - 0.120	12%	0.176 - 0.193	0.043 - 0.064	0.125 - 0.135	48
	47	1.0 - 1.5	3.6 - 4.7	33% - 35%	0.824 - 0.886	0.101 - 0.111	11%	0.154 - 0.175	0.023 - 0.042	0.112 - 0.124	47
	46	0.6 - 0.9	2.3 - 3.5	-	0.764 - 0.823	0.092 - 0.100	10%	0.138 - 0.153	0.008 - 0.022	0.104 - 0.111	46
	45	0.0 - 0.5	1.1 - 2.2	25% - 32%	0.703 - 0.763	0.081 - 0.091	-	0.118 - 0.137	0.000 - 0.007	0.094 - 0.103	45
Low Risk	44	-	0.0 - 1.0	21% - 24%	0.651 - 0.702	0.071 - 0.080	9%	0.097 - 0.117	-	0.080 - 0.093	44
	43	-	-	20%	0.589 - 0.650	0.061 - 0.070	8%	0.081 - 0.096	-	0.068 - 0.079	43
	42	-	-	-	0.538 - 0.588	0.050 - 0.060	-	0.059 - 0.080	-	0.059 - 0.067	42
	41	-	-	13% - 19%	0.478 - 0.537	0.042 - 0.049	7%	0.042 - 0.058	-	0.047 - 0.058	41
	40	-	-	-	0.396 - 0.477	0.033 - 0.041	6%	0.031 - 0.041	-	0.037 - 0.046	40
Moderate Risk	39	-	-	-	0.367 - 0.395	0.024 - 0.032	5%	0.001 - 0.030	-	0.027 - 0.036	39
	38	-	-	0% - 12%	0.285 - 0.366	-	4%	0.000	-	0.020 - 0.026	38
	37	-	-	-	0.232 - 0.284	0.000 - 0.023	-	-	-	0.003 - 0.019	37
	36	-	-	-	0.169 - 0.231	-	1-3%	-	-	0.000 - 0.002	36
	35	-	-	-	0.111 - 0.168	-	-	-	-	-	35
High Risk	< 35	-	-	-	< 0.111	-	0%	-	-	-	< 35

Legend: Current Rate/T-score Previous T-score

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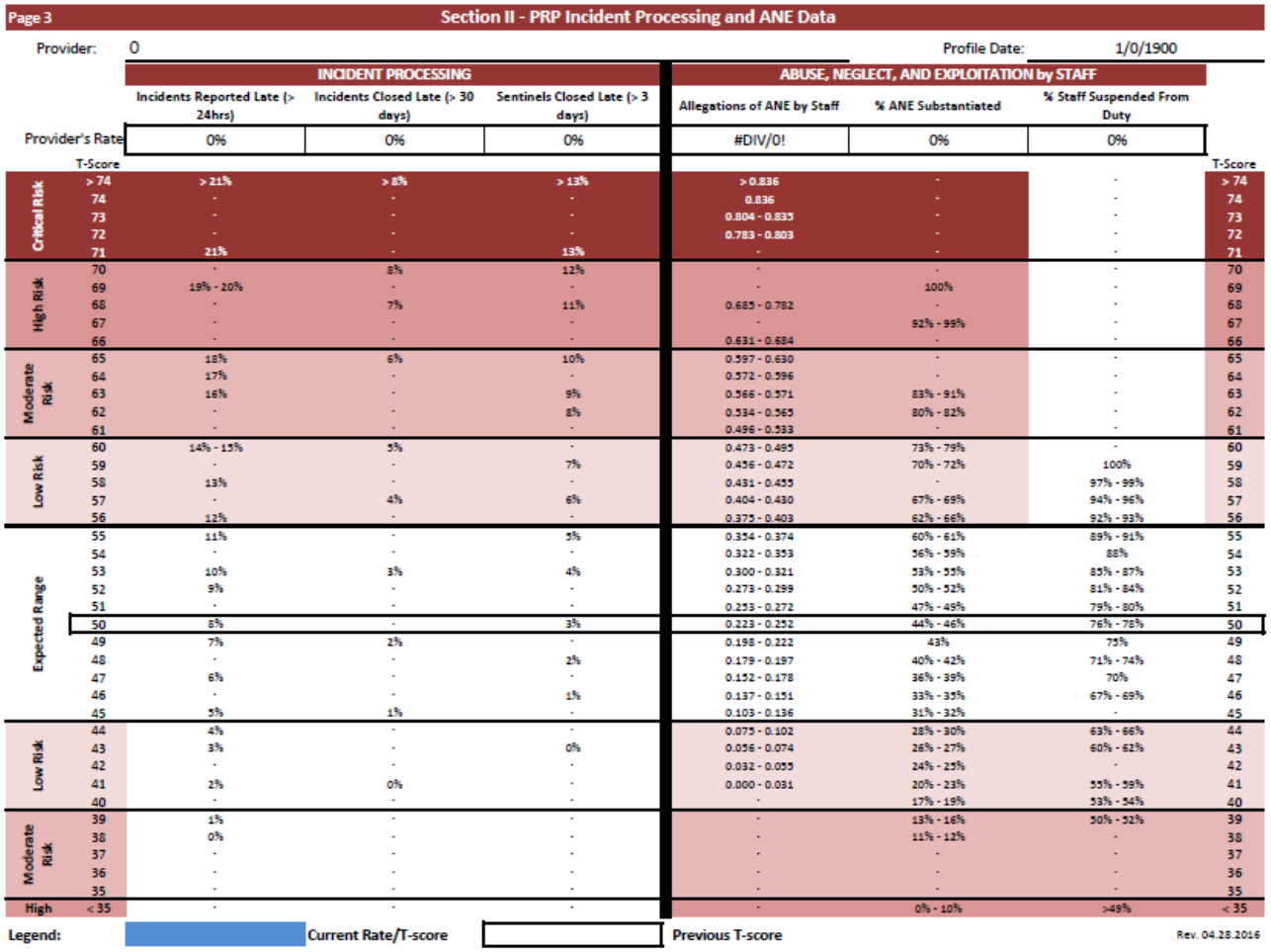

Page 3 — Section II - PRP Incident Processing and ANE Data

Provider: 0 — Profile Date: 1/0/1900

	T-Score	INCIDENT PROCESSING: Incidents Reported Late (> 24hrs)	INCIDENT PROCESSING: Incidents Closed Late (> 30 days)	INCIDENT PROCESSING: Sentinels Closed Late (> 3 days)	ABUSE, NEGLECT, AND EXPLOITATION by STAFF: Allegations of ANE by Staff	ABUSE, NEGLECT, AND EXPLOITATION by STAFF: % ANE Substantiated	ABUSE, NEGLECT, AND EXPLOITATION by STAFF: % Staff Suspended From Duty	T-Score
Provider's Rate		0%	0%	0%	#DIV/0!	0%	0%	
Critical Risk	> 74	> 21%	> 8%	> 13%	> 0.836	-	-	> 74
	74	-	-	-	0.836	-	-	74
	73	-	-	-	0.804 - 0.835	-	-	73
	72	-	-	-	0.783 - 0.803	-	-	72
	71	21%	-	13%	-	-	-	71
High Risk	70	-	8%	12%	-	-	-	70
	69	19% - 20%	-	-	-	100%	-	69
	68	-	7%	11%	0.685 - 0.782	-	-	68
	67	-	-	-	-	92% - 99%	-	67
	66	-	-	-	0.631 - 0.684	-	-	66
Moderate Risk	65	18%	6%	10%	0.597 - 0.630	-	-	65
	64	17%	-	-	0.572 - 0.596	-	-	64
	63	16%	-	9%	0.566 - 0.571	83% - 91%	-	63
	62	-	-	8%	0.534 - 0.565	80% - 82%	-	62
	61	-	-	-	0.496 - 0.533	-	-	61
Low Risk	60	14% - 15%	5%	-	0.473 - 0.495	73% - 79%	-	60
	59	-	-	7%	0.456 - 0.472	70% - 72%	100%	59
	58	13%	-	-	0.431 - 0.455	-	97% - 99%	58
	57	-	4%	6%	0.404 - 0.430	67% - 69%	94% - 96%	57
	56	12%	-	-	0.375 - 0.403	62% - 66%	92% - 93%	56
Expected Range	55	11%	-	5%	0.354 - 0.374	60% - 61%	89% - 91%	55
	54	-	-	-	0.322 - 0.353	56% - 59%	88%	54
	53	10%	3%	4%	0.300 - 0.321	53% - 55%	85% - 87%	53
	52	9%	-	-	0.273 - 0.299	50% - 52%	81% - 84%	52
	51	-	-	-	0.253 - 0.272	47% - 49%	79% - 80%	51
	50	8%	-	3%	0.223 - 0.252	44% - 46%	76% - 78%	50
	49	7%	2%	-	0.198 - 0.222	43%	75%	49
	48	-	-	2%	0.179 - 0.197	40% - 42%	71% - 74%	48
	47	6%	-	-	0.152 - 0.178	36% - 39%	70%	47
	46	-	-	1%	0.137 - 0.151	33% - 35%	67% - 69%	46
	45	5%	1%	-	0.103 - 0.136	31% - 32%	-	45
Low Risk	44	4%	-	-	0.075 - 0.102	28% - 30%	63% - 66%	44
	43	3%	-	0%	0.056 - 0.074	26% - 27%	60% - 62%	43
	42	-	-	-	0.032 - 0.055	24% - 25%	-	42
	41	2%	0%	-	0.000 - 0.031	20% - 23%	55% - 59%	41
	40	-	-	-	-	17% - 19%	53% - 54%	40
Moderate Risk	39	1%	-	-	-	13% - 16%	50% - 52%	39
	38	0%	-	-	-	11% - 12%	-	38
	37	-	-	-	-	-	-	37
	36	-	-	-	-	-	-	36
	35	-	-	-	-	-	-	35
High	< 35	-	-	-	-	0% - 10%	>49%	< 35

Legend: Current Rate/T-score | Previous T-score

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Page 4 — **Section III - PRP Behavioral Data**

Provider: 0 Profile Date: 1/0/1900

		BEHAVIORAL INCIDENTS								FAILURES				
		Aggression	Sexual Assault	Elopement	Suicide Attempt	Suicidal Thoughts / Ideations	Pica	Property Damage	Self-Injurious Behavior	PRN for Behavior	Physical Restraints	Arrests	Prohibited Intervention	
Provider's Rate		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0	
	T-Score													T-Score
Critical Risk	> 74	> 0.417	>0.0012	> 0.195	>0.0019	>0.0309	>0.0078	> 0.054	>0.110	> 0.439	> 0.124	>0.0099	>1	> 74
	74	.	.	0.172 - 0.195	.	.	.	.	.	.	0.122- 0.124	.	.	74
	73	.	.	0.164 - 0.171	0.0019	.	0.0074-0.0078	.	.	.	0.119 - 0.121	.	.	73
	72	.	0.0010-0.0012	0.160 - 0.163	.	0.0271-0.0309	.	0.047 - 0.054	.	.	.	.	.	72
	71	.	.	.	.	0.0268-0.0270	.	0.046	0.098 - 0.110	0.244 - 0.439	0.111 - 0.118	0.0086-0.0099	.	71
High Risk	70	0.345 - 0.417	.	0.152 - 0.159	.	.	.	.	0.095 - 0.097	.	0.106 - 0.110	0.0081-0.0085	.	70
	69	.	.	0.143 - 0.151	0.0016-0.0018	0.0243-0.0267	0.0063-0.0073	.	.	.	0.104 - 0.105	.	.	69
	68	0.324 - 0.344	.	0.141 - 0.142	.	.	.	0.040 - 0.045	0.087 - 0.094	.	.	0.0075-0.0080	.	68
	67	.	0.0009	.	.	.	.	.	0.084 - 0.086	.	.	0.0073-0.0074	.	67
	66	0.301 - 0.323	0.0008	.	.	.	.	0.036 - 0.039	.	.	.	.	.	66
Moderate Risk	65	0.289 - 0.300	.	.	0.0013-0.0015	0.0203-0.0242	0.0051-0.0062	.	0.077 - 0.083	.	.	.	.	65
	64	0.280 - 0.288	.	0.114 - 0.140	.	0.0192-0.0202	.	0.033 - 0.035	.	0.181 - 0.243	.	0.0063-0.0072	1	64
	63	0.266 - 0.279	0.0007	.	.	0.0188-0.0191	0.0046-0.0050	0.031-0.032	0.070 - 0.076	0.167 - 0.180	0.076 - 0.103	0.0060-0.0062	.	63
	62	0.254 - 0.265	.	0.103 - 0.113	.	.	0.0042-0.0045	0.030	.	0.156 - 0.166	0.074 - 0.075	0.0056-0.0059	.	62
	61	0.248 - 0.253	.	0.101 - 0.102	.	0.0166-0.0187	.	.	.	0.148 - 0.155	.	0.0052-0.0055	.	61
Low Risk	60	.	.	0.091 - 0.100	.	0.0154-0.0165	0.0037-0.0041	0.026 - 0.029	0.061 - 0.069	.	0.067 - 0.073	0.0048-0.0051	.	60
	59	0.224 - 0.247	.	0.086 - 0.090	.	.	0.0035-0.0036	.	0.058 - 0.060	0.124 - 0.147	0.061 - 0.066	.	.	59
	58	0.217 - 0.223	.	0.083 - 0.085	0.0008-0.0012	0.0140-0.0153	0.0032-0.0034	.	0.054 - 0.057	.	.	0.0041-0.0047	.	58
	57	0.202 - 0.216	.	0.080 - 0.082	.	0.0130-0.0139	0.0029-0.0031	.	0.050 - 0.053	0.105 - 0.123	0.049 - 0.060	0.0037-0.0040	.	57
	56	0.189 - 0.201	0.0004-0.0006	0.070 - 0.079	0.0007	0.0120-0.0129	0.0026-0.0028	0.019 - 0.025	0.048 - 0.049	0.095 - 0.104	.	.	.	56
Expected Range	55	0.175 - 0.188	.	.	.	0.0109-0.0119	.	.	.	0.086 - 0.094	.	0.0032-0.0036	.	55
	54	0.165 - 0.174	.	0.060 - 0.069	.	0.0096-0.0108	.	0.016 - 0.018	0.040 - 0.047	0.079 - 0.085	0.040 - 0.048	0.0030-0.0031	.	54
	53	0.152 - 0.164	0.0003	0.052 - 0.059	0.0004-0.0006	.	0.0019-0.0025	0.015	0.037 - 0.039	0.067 - 0.078	0.034 - 0.039	.	.	53
	52	0.141 - 0.151	.	0.050 - 0.051	0.0003	0.0076-0.0095	.	0.013 - 0.014	0.035 - 0.036	0.057 - 0.066	0.028 - 0.033	0.0020-0.0029	.	52
	51	0.131 - 0.140	0.0002	0.042 - 0.049	.	0.0075	0.0013-0.0018	0.011 - 0.012	0.030 - 0.034	0.048 - 0.056	0.024 - 0.027	0.0018-0.0019	.	51
	50	0.119 - 0.130	.	0.036 - 0.041	0.0002	0.0056-0.0074	0.0010-0.0012	0.010	0.026 - 0.029	0.037 - 0.047	0.022 - 0.023	.	.	50
	49	0.109 - 0.118	0.0001	0.030 - 0.035	0.0001	.	0.0008-0.0009	0.007 - 0.009	0.023 - 0.025	0.026 - 0.036	0.016 - 0.021	0.0013-0.0017	.	49
	48	0.097 - 0.108	.	0.026 - 0.029	0.0000	0.0037-0.0055	.	0.006 - 0.006	0.021 - 0.022	0.016 - 0.025	0.011 - 0.015	0.0008-0.0012	.	48
	47	0.088 - 0.096	0.0000	0.019 - 0.025	.	0.0032-0.0036	0.0002-0.0007	0.004 - 0.005	0.017 - 0.020	0.005 - 0.015	0.007 - 0.010	0.0000-0.0007	.	47
	46	0.076 - 0.087	.	0.014 - 0.018	.	0.0019-0.0031	0.0000-0.0001	0.003	0.013 - 0.016	0.000 - 0.004	0.003 - 0.006	-	.	46
	45	0.065 - 0.075	-	0.008 - 0.013	-	0.0008-0.0018	-	0.000 - 0.002	0.010 - 0.012	-	0.000 - 0.002	-	0	45
Low Risk	44	0.053 - 0.064	-	0.003 - 0.007	-	0.0000-0.0007	-	-	0.006 - 0.009	-	-	-	-	44
	43	0.040 - 0.052	-	0.000 - 0.002	-	-	-	-	0.004 - 0.005	-	-	-	-	43
	42	0.030 - 0.039	-	-	-	-	-	-	0.000 - 0.003	-	-	-	-	42
	41	0.018 - 0.029	-	-	-	-	-	-	-	-	-	-	-	41
	40	0.006 - 0.017	-	-	-	-	-	-	-	-	-	-	-	40
Moderate Risk	39	0.000 - 0.005	-	-	-	-	-	-	-	-	-	-	-	39
	38	-	-	-	-	-	-	-	-	-	-	-	-	38
	37	-	-	-	-	-	-	-	-	-	-	-	-	37
	36	-	-	-	-	-	-	-	-	-	-	-	-	36
	35	-	-	-	-	-	-	-	-	-	-	-	-	35
High	< 35	-	-	-	-	-	-	-	-	-	-	-	-	< 35

Legend: Current Rate/T-score | *Enter Date Range* | Previous T-score

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Section IV - PRP Medication and Medical Data

Provider: 0

Profile Date: 1/0/1900

		MEDICATION ERRORS	MEDICAL INCIDENTS			MEDICAL ER VISITS	
		Medication Errors (all)	Choking w/Intervention	Falls w/Injury	Injuries	Medical ER Visits	
Provider's Rate		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
	T-Score						T-Score
Critical Risk	> 74	> 0.704	>0.0285	>0.258	> 0.199	> 0.452	> 74
	74	-	-	0.250 - 0.258	-	0.440 - 0.452	74
	73	-	-	-	-	-	73
	72	-	0.0218-0.0285	-	-	-	72
	71	-	-	0.230 - 0.249	-	0.406 - 0.439	71
High Risk	70	0.561 - 0.704	0.0199-0.0217	-	0.167 - 0.199	0.401 - 0.405	70
	69	0.539 - 0.560	0.0191-0.0198	-	0.159 - 0.166	-	69
	68	0.527 - 0.538	0.0189-0.0190	-	0.155 - 0.158	0.374 - 0.400	68
	67	0.512 - 0.526	-	-	0.150 - 0.154	0.363 - 0.373	67
	66	-	0.0173-0.0188	0.195 - 0.229	-	0.356 - 0.362	66
Moderate Risk	65	0.468 - 0.511	0.0160-0.0172	0.188 - 0.194	0.138 - 0.149	0.342 - 0.355	65
	64	0.449 - 0.467	0.0152-0.0159	0.175 - 0.187	0.136 - 0.137	-	64
	63	0.429 - 0.448	-	0.168 - 0.174	0.129 - 0.135	0.316 - 0.341	63
	62	0.414 - 0.428	0.0136-0.0151	0.161 - 0.167	-	0.303 - 0.315	62
	61	0.393 - 0.413	0.0128-0.0135	0.156 - 0.160	0.117 - 0.128	0.292 - 0.302	61
Low Risk	60	0.381 - 0.392	0.0119-0.0127	0.151 - 0.155	0.111 - 0.116	0.286 - 0.291	60
	59	0.358 - 0.380	0.0116-0.0118	0.142 - 0.150	0.105 - 0.110	0.272 - 0.285	59
	58	0.347 - 0.357	0.0105-0.0115	0.135 - 0.141	0.103 - 0.104	0.258 - 0.271	58
	57	0.321 - 0.346	0.0098-0.0104	0.126 - 0.134	0.095 - 0.102	0.250 - 0.257	57
	56	-	0.0088-0.0097	-	0.091 - 0.094	0.236 - 0.249	56
Expected Range	55	-	0.0080-0.0087	0.113 - 0.125	0.084 - 0.090	0.225 - 0.235	55
	54	0.265 - 0.320	0.0071-0.0079	0.106 - 0.112	-	0.213 - 0.224	54
	53	0.249 - 0.264	0.0063-0.0070	0.099 - 0.105	0.074 - 0.083	0.207 - 0.212	53
	52	0.230 - 0.248	-	0.092 - 0.098	0.068 - 0.073	0.192 - 0.206	52
	51	0.212 - 0.229	0.0047-0.0062	0.084 - 0.091	0.062 - 0.067	0.180 - 0.191	51
	50	0.191 - 0.211	0.0041-0.0046	0.078 - 0.083	0.060 - 0.061	0.168 - 0.179	50
	49	0.179 - 0.190	0.0034-0.0040	0.070 - 0.077	0.051 - 0.059	0.160 - 0.167	49
	48	0.155 - 0.178	0.0025-0.0033	0.063 - 0.069	0.047 - 0.050	0.145 - 0.159	48
	47	0.145 - 0.154	-	0.057 - 0.062	0.042 - 0.046	0.133 - 0.144	47
	46	0.120 - 0.144	0.0008-0.0024	0.052 - 0.056	0.035 - 0.041	0.123 - 0.132	46
	45	0.103 - 0.119	0.000-0.0007	0.045 - 0.051	0.032 - 0.034	0.111 - 0.122	45
Low Risk	44	0.084 - 0.102	-	0.037 - 0.044	0.025 - 0.031	0.100 - 0.110	44
	43	0.068 - 0.083	-	0.033 - 0.036	0.020 - 0.024	0.095 - 0.099	43
	42	0.048 - 0.067	-	0.023 - 0.032	0.014 - 0.019	0.086 - 0.094	42
	41	0.029 - 0.047	-	0.016 - 0.022	0.010 - 0.013	0.072 - 0.085	41
	40	0.014 - 0.028	-	0.011 - 0.015	-	0.062 - 0.071	40
Moderate Risk	39	0.000 - 0.013	-	0.001 - 0.010	0.000 - 0.009	0.053 - 0.061	39
	38	-	-	0.000	-	0.037 - 0.052	38
	37	-	-	-	-	0.029 - 0.036	37
	36	-	-	-	-	-	36
	35	-	-	-	-	-	35
High	< 35	-	-	-	-	< 0.028	< 35

Legend: Current Rate/T-score | Previous T-score

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Page 6

0

Complaint Allegations

0

Allegation Type	Investigation #	Substantiated?	CAP Required?

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0

Sentinel Incident Reports

0

Incident #	Incident Date

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8	PROVIDER REVIEW PROFILE - TECHNICAL INFORMATION	
Below is a list of definitions as well as calculations utilized to generate the rates that are captured on the different profiles. In addition, T Scores have a Mean of 50 and a Standard Deviation (measure of variability) of 10. Within the profiles, 1/2 Standard Deviations are marked.		
	Worksheet (Page 1)	
Size and Complexity	Monthly Client Average:	The average number of clients a provider supports each month receiving RH10, RH20, RD and SFC (average calculated for a 12 month period).
	Average ALGO:	The average ALGO (utilized for rate setting based on client needs) across all clients the provider delivers residential habilitation services (RH10, RH20, and SFC).
	Average Behavioral Factor:	The average Behavioral Factor (level of behavioral challenge/needs) across all clients the provider delivers residential habilitation services (RH10, RH20, and SFC). The Behavioral Factor is one of the data elements utilized to compute an individual's overall ALGO score.
	Average Health Factor:	The average Health Factor (level of medical challenge/needs) across all clients the provider delivers residential habilitation services (RH10, RH20, and SFC). The Health Factor is one of the data elements utilized to compute an individual's overall ALGO score.
	Section I - PRP Complaints and Incident Data (Page 2)	
Complaints	Complaints:	(Total number of complaints for the year (filed with BQIS) * 100) / Monthly Client Average).
	Number of Complaint Issues Substantiated:	((Total number of issues identified within all complaints (filed with BQIS) for the year that were substantiated * 100) / Monthly Client Average).
	% of Substantiated Issues Requiring a CAP:	Percentage of the substantiated issues that required a CAP by BQIS during an investigation.
Incident Data	Incidents:	((Total number of incidents for the year + 0.001 (constant added to allow examination of low scores)) / Monthly Client Average) / Average ALGO.
	Sentinel Incidents:	((Total number of annual incidents classified as sentinel + 0.001 (constant added to allow examination of low scores)) / Monthly Client Average) / Average ALGO.
	% of Incidents Made Sentinel:	The number of sentinel incidents for the year / the total number of incident reports for the year.
	Behavioral Incidents:	Total score made up of the following incident categories: Aggression, Sexual Assault, Elopement, Suicidal Attempts, Suicidal Thoughts, Pica, Property Damage, and Self-Injury. The rate is calculated by: ((Total Behavioral Score + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Behavioral Failures:	Behavioral Failures are made up of the following incident categories: PRN for Behavior, Physical Restraints, Mechanical Restraints, Prone Restraints, Seclusion, Use of Aversives, and Client Arrests. The rate is calculated by: ((Total Behavioral Failure Score + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Medical Incidents:	Total score made up of the following incident categories: Choking, Falls, and Injuries. The rate is calculated by: ((Total Medical Incidents + 0.001) / Monthly Client Average) / Average Health Factor.
CERT	CERT:	The total score (probes) from the Comprehensive Evaluation and Review Tool (CERT), based on 181 probes reviewed (reviews after 10/1/11, adjusted for number - i.e., 10/1/11 - 10/31/13 multiplied by 0.4776; 11/1/13 forward multiplied by 0.8303).

Section II - PRP Incident Processing and ANE Data (Page 3)		
Incident Processing	Incidents Reported Late:	Percentage of incidents reported late (more than 24 hours after knowledge of the incident).
	Incidents Closed Late:	Percentage of incidents that were closed late (more than 30 days after incident date).
	Sentinel Incidents Closed Late:	Percentage of sentinel incidents that were closed late (more than 3 days after classification as sentinel).
ANE by Staff	Allegations of ANE by Staff:	(All allegations of abuse, neglect, and exploitation that were attributed to staff + 0.001) / Monthly Client Average.
	% Substantiated:	For allegations that have data on substantiation available, this is: (The number of ANE allegations substantiated / total number substantiated + not substantiated) * 100
	% of Staff Suspended From Duty (pending results from investigation):	For allegations of ANE, staff must be suspended pending the outcome of the investigation. For allegations that have data on staff suspension, this is (The number of ANE allegations where staff were suspended / total number of allegations with suspension + without suspension) * 100
Section III - PRP Behavioral Data (Page 4)		
Behavioral Incidents	Aggression:	((Total incidents involving aggression directed at others (e.g., other clients, staff, community members, etc.) + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Sexual Assault:	((Total incidents involving sexual assault + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Elopement:	((Total incidents involving elopement + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Suicidal Attempts:	((Total incidents involving suicide attempts + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Suicidal Thoughts:	((Total incidents involving suicide thoughts + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Pica:	((Total incidents involving pica + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Property Damage:	((Total incidents involving property damage + 0.001) / Monthly Client Average) / Average Behavioral Factor.
	Self-Injury:	((Total incidents involving self-injurious behavior + 0.001) / Monthly Client Average) / Average Behavioral Factor.
Behavioral Failures	PRN for Behavior:	((Total incidents involving use of a PRN for behavior control + 0.001)/ Monthly Client Average) / Average Behavioral Factor.
	Physical Restraint:	((Total incidents involving use of a physical/manual restraint for behavior control +0.001) / Monthly Client Average) / Average Behavioral Factor.
	Client Arrests:	((Total incidents where a client was arrested +0.001)/ Monthly Client Average) / Average Behavioral Factor.
	Prohibited Intervention:	Total incidents involving use of mechanical restraints, prone restraint, seclusion and aversives.

Section IV - PRP Medication and Medical Data (Page 5)		
ER	Medical ER Visits:	((Annual incidents where a client is taken to the ER for Medical Treatment/Evaluation + 0.001) / Monthly Client Average) / Average Health Factor.
Medical Incidents	Choking Requiring Intervention:	((Annual incidents of choking + 0.001) / Monthly Client Average) / Average Health Factor.
	Falls w/Injury:	((Annual falls with injuries (e.g., producing an injury) +0.001) / Monthly Client Average) / Average Health Factor.
	Injuries:	((Annual injuries reported as incidents (e.g., fractures) + 0.001) / Monthly Client Average) / Average Health Factor.
Errors	All Medication Errors:	((Total number of medication errors reported for the year (e.g., missed dose, wrong dose, wrong route, etc.) +0.001)/ Monthly Client Average) / Average Health Factor.

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Indiana Division of Disability and Rehabilitative Services
Bureau of Quality Improvement Services (BQIS)

Re-Approval Assessment

Provider Name:
Data Assessed For The Period Of:
Initial Assessment Due Date:

Provider Corporate Office Street Address:
City, State, Zip:
Provider Corporate Mailing Address:
City, State, Zip:

Name of Chief Executive Officer:	Click here to enter text.
Email Address:	Click here to enter text.
Completed by (name):	Click here to enter text.
Title:	Click here to enter text.
Telephone Number:	Click here to enter text.
Email Address:	Click here to enter text.
Date Initially Submitted to BQIS:	Click here to enter a date.
Date Addendum Submitted to BQIS:	Click here to enter a date.

BQIS Provider Re-Approval Process Contact:
Shelly Thomas
Division of Disability and Rehabilitative Services
Indiana Family and Social Services Administration
402 W. Washington Street, Room 453
Indianapolis, IN 46204
317-234-2764
Shelly.Thomas@fssa.in.gov

PROVIDER RE-APPROVAL COMPLETION GUIDE

PROVIDER RE-APPROVAL

The provider re-approval process is designed to validate that a provider maintains policies, procedures and systems that ensure the needs of consumers are met according to Individualized Support Plans, Behavioral Support Plans and Risk Plans. Providers must substantiate that their systems (i.e., policies, procedures, protocols, staff training, etc.), are designed to address quality improvement and all processes are aligned to offer programs with health, safety and welfare at their core. The Bureau of Quality Improvement Services (BQIS) will utilize Provider Review Profile data, the completed Re-Approval Assessment, and any requested addenda to justify a recommendation of a re-approval term of 6, 12, or 36 months.

DOCUMENTS

To perform a thorough fact based review, a provider-specific report has been developed and is titled the **Provider Review Profile (PRP)** (Attachment D). Once the provider has reviewed and analyzed its PRP, the provider then completes the **Re-Approval Assessment** (Attachment F) document.

PROVIDER REVIEW PROFILE (PRP) – ATTACHMENT D

The PRP is a data-driven report that allows the provider to assess its organization's data against a benchmark of relatively similar providers (e.g. client count, Algo levels). Analyzing this data is pivotal in reviewing the provider's performance. The PRP is structured to provide data in multiple risk areas.

The first page of the PRP is a worksheet which contains the raw data for the provider. The next section contains risk area data which includes complaints, general incident data, incident processing data, data for abuse, neglect and exploitation, behavioral data, and medical data. The final section of the PRP is a technical guide that includes the calculations for each of the risk areas. For each of the risk areas, the provider should analyze the raw data to determine one or more reasons for being out of the expected range (above or below). Attachment E in the re-approval documents is an Excel spreadsheet of all incident reports for the timeframe in the PRP. This data should be an essential tool in conducting the data analysis.

RE-APPROVAL ASSESSMENT – ATTACHMENT F

The Re-Approval Assessment is designed to detail the data analysis conducted, convey organizational processes, demonstrate compliance, and identify areas of improvement. There are six sections. The first four sections are linked to the risk areas in the PRP: complaints and incident data; incident processing and ANE data; behavioral data; and medication and medical data.

For each risk area identified as above or below the expected range, the provider will explain the reason for being out of expected range. Data that falls *below the expected range* or *above the expected range* may be indicative of issues within your organization's operational systems. Data that is above or below that of your peer group is not where an organization's data should fall and requires a full analysis of the data to explain the results. A review of the data with a quantitative analysis may provide the information to assist in determining the root cause. The results of this analysis are documented on the Re-Approval Assessment. For the re-approval process, providers should consider how their respective PRP data is reflective of quantitative and qualitative data: quantitative numbers are indicative of measureable facts, but the qualitative data is suggestive of what methods your organization uses, and whether or not they are working to deliver outcomes, your organization expects.

Tips: When documenting the reasons for the variation from the norm (being above or below the expected range), consider issues such as individual-specific data that may be affecting your rates (e.g., repeat incidents attributed to a few consumers). Detail if there is evidence to suggest data is trending in the right direction (i.e., showing improvement).

Once the data has been analyzed, the provider is asked a series of questions to assess how performance in these categories is monitored and how service level improvements are made based on the data. The remaining two sections of the Re-Approval Assessment are focused on the broader subject of providing quality care and services.

Document Submission

The completed Re-Approval Assessment is due on or before the due date noted on the cover page and must be submitted electronically to BQIS at BQISReporting@fssa.in.gov. When submitting this document, the provider may also attach to the email (as separate documents and labeled as exhibits) copies of supporting documents that will aid in the review of the provider's systems and processes; **however, these do not take the place of responding to the Re-approval Assessment questions**. All supporting documents must be referenced as exhibits within the Re-Approval Assessment. Once submitted, BQIS will review the completed Re-Approval Assessment. Providers may be asked to meet in person or via telephone for the purpose of BQIS explaining any clarifying questions that require further explanation/detail by the provider. The provider through the submission of a re-approval addendum will submit the clarifying information. *Note: Failure to submit a written Re-Approval Assessment by the established due date will eliminate the opportunity for provider clarification. Additionally, it may result in the provider receiving a re-approval term that is not preferred and/or a referral to the DDRS Sanctions Committee.*

[%]% of the Risk Categories in the Expected Range

Client Count =[Client Count] Algo = [Algo] Behavioral Factor = [BF] Health Factor = [HF]

Data Analysis

Section I - PRP Complaints and Incident Data*		
Risk Area	Below the expected range	Above the expected range
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		

[Providers new to the re-approval process will have CERT data indicated in this section]*

Provider Analysis - Complaints and Incident Data (Note: Behavioral and medical data are detailed in a separate section)

1) ***For each of the risk areas shown above, explain in detail why the data indicates your organization was above or below the expected range compared to peer organizations.***
Click here to enter text.

2) ***A. Describe the activities your organization implements to prevent incidents from occurring.***
B. Describe how those activities have prevented incidents from occurring.
Click here to enter text.

3) ***A. Provide a summary of the initial and annual training staff receive on incident identification and reporting.***
B. What opportunities exist for re-training and refresher training?
C. On a day-to-day, informal basis, how do you ensure staff maintain continuous competency in identifying and reporting incidents?
Click here to enter text.

4) ***Describe in detail the process for analyzing incident report data.***
Click here to enter text.

5) ***How is information regarding specific incidents or trends communicated to all staff to bring awareness to the identified issue?***
Click here to enter text.

6) ***Describe your internal process for ensuring the health, safety and welfare of the individual after filing an incident report with the state.***
Click here to enter text.

7) ***Please describe how your organization addresses concerns that are informally expressed regarding an individual enrolled in your services?***
(Note: This is not about complaints, but rather how the organization handles concerns or other similar issues such as missing personal items, meals not to the individual's liking, etc.)
Click here to enter text.

8) ***If this Re-Approval Assessment includes CERT* data [providers new to the re-approval process], describe how your organization ensures the procedures implemented to correct the identified issues in the CERT continue to be effective. (Type N/A if not applicable to your organization.)***
Click here to enter text.

Section II - PRP Incident Processing and Abuse/Neglect/Exploitation Data		
Risk Area	Below the expected range	Above the expected range
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		

Provider Analysis - Incident Processing and Abuse/Neglect/Exploitation Data (Note: Behavioral and medical data are detailed in a separate section)

1) ***For each of the risk areas shown above, explain <u>in detail</u> why the data indicates your organization was above or below the expected range compared to peer organizations.***
Click here to enter text.

2) ***Explain how your incident reporting process minimizes the potential for late reports.***
Click here to enter text.

3) ***Explain how your organization investigates allegations of Abuse/Neglect/Exploitation by staff.***
Click here to enter text.

4) ***A. Provide a summary of the initial and annual training staff receive on abuse, neglect and exploitation.***
B. What opportunities exist for re-training and refresher training?
C. On a day-to-day informal basis, how do you ensure staff maintain continuous competency regarding abuse, neglect and exploitation?
Click here to enter text.

Section III - PRP Behavioral Data		
Risk Area	Below the expected range	Above the expected range
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		

Provider Analysis - Behavioral Data

1) ***For each of the risk areas shown above, explain <u>in detail</u> why the data indicates your organization was above or below the expected range compared to peer organizations.***
Click here to enter text.

2) ***Provide an overview of the pro-active activities your organization uses to minimize and/or address behavioral risks.***
Click here to enter text.

3) ***A. Submit a copy of your organization's policy which clearly outlines the interventions that are prohibited within the home and community based waiver program and by the state.***
B. Explain how your organization ensures staff understands what constitutes an intervention that is prohibited by the state.
C. On a day-to-day informal basis, how do you ensure staff maintain continuous competency regarding interventions prohibited by the state?
Click here to enter text.

4) ***If your PRP data indicates the use of a prohibited intervention was implemented, please answer the following questions:***
A. Describe the circumstances that led the staff to implement a prohibited intervention.
B. Describe what your organization learned from this event.
C. Indicate any improvements or changes your organization made as a result of this event.
Click here to enter text.

Section IV - PRP Medication and Medical Data		
Risk Area	Below the expected range	Above the expected range
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		
Risk Area – low/mod/high/critical risk		

Provider Analysis - Medication and Medical Incidents

1) ***For each of the risk areas shown above, explain <u>in detail</u> why the data indicates your organization was above or below the expected range compared to peer organizations.***
Click here to enter text.

2) ***Describe, in detail, the process your organization uses to analyze medication errors.***
Click here to enter text.

3) ***A. Describe the overall process to develop recommendations to reduce the risk of future medication errors.***
B. Indicate how the recommendations are documented.
C. Describe the overall process to determine if a proposed recommendation is implemented.

(Note: response should include all recommendations, not just staff errors.)
Click here to enter text.

4) ***Describe the overall process for determining if the recommendations were effective in reducing medication errors.***
Click here to enter text.

5) ***A. Provide a summary of the initial and annual training staff receive on medication administration training.***
B. What opportunities exist for re-training and refresher training?
C. Who (by title) is responsible for conducting the initial medication administration training?
D. Who (by title) is responsible for conducting the annual medication administration training?
Click here to enter text.

6) ***On a day-to-day informal basis, how do you ensure staff maintain continuous competency regarding medication administration?***
Click here to enter text.

7) ***A. Describe how risk plans are developed and revised, when needed.***
B. Who (by title) is responsible for development and revision of risk plans?
Click here to enter text.

8) ***A. Describe how staff are trained on risk plans.***
B. Who (by title) is responsible for the training of staff on risk plans?
C. Describe how staff's implementation of risk plans is monitored.
Click here to enter text.

9) ***If an individual has Wellness Coordination as a service:***
A. Who (by title) is responsible for the development/revision of risk plans?
B. Who (by title) is responsible for the training of staff on risk plans?
Click here to enter text.

Quality Assurance / Quality Improvement Review

Section V - Service Delivery & Consumer Supports

1) ***A. As an organization, what data does your organization track?***
B. How does your organization analyze the data collected (i.e. process and frequency) to verify compliance with program/state requirements?
Click here to enter text.

2) ***A. Describe how your organization determines if a policy, protocol or process is identified as being ineffective.***
B. If a policy, protocol or process is identified as being ineffective, what steps are taken to correct the inefficiency?
Click here to enter text.

3) ***A. Describe how your organization verifies Individualized Support Plans, Behavioral Support Plans, and Risk Plans are implemented and followed as written.***
B. How would you know if staff were not implementing the Individualized Support Plans, Behavioral Support Plans, and Risk Plans as they are trained?
Click here to enter text.

4) ***Describe your process to identify and respond to changes in a consumer's needs in a timely manner.***
Click here to enter text.

5) ***A. Provide specifics on new employee orientation, including the training schedule and subjects covered.***
B. Please indicate how training records are maintained for all employees.
Click here to enter text.

Section VI – Improvement Plan

1) ***A. What new policies and systems have been implemented to support better quality of services?***
B. Indicate the date(s) of implementation.
Click here to enter text.

2) ***A. Based on your analysis of the data used in the re-approval process, what changes will be made within the next 6-months to facilitate improvement in the organization's systems, policies and procedures?***
B. Provide detail regarding who in your organization will implement the change(s) and the timetable of the change(s).
Click here to enter text.

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

DDRS Waiver Provider Re-Approval
Submission Checklist

DIRECTIONS:

- Complete the documents listed below.
- Each document must be saved as a separate file, labeled appropriately, and attached to the email. Depending on the size of the documents, multiple emails may be necessary.
- Email all documents to BQISReporting@fssa.in.gov.

☐ Accreditation documentation including:
  - Accreditation Award Letter;
  - Survey Report; and
  - Any required plans for improvement

☐ DDRS Service List (Attachment A) – Confirmed/Updated
  - Review the following and update as needed:
    - Address
    - Contact Name
    - Phone Number
    - Additional Phone Numbers
    - Additional Emails
  - Review the services listed – please note ones that are inaccurate
  - Sign and date the document
  - Scan and save as a PDF file
  - Name the file: *ProviderName_ServiceList_Confirmed_Date*

☐ Completed Re-Approval Assessment (Attachment F)
  - All supporting documents are referenced as exhibits within the Re-Approval Assessment.
  - Name the saved Re-Approval Assessment file: *ProviderName_Re-Approval Assessment_Initial_Date*
  - Save supporting documents as separate files. Each file should be titled: *ProviderName_Re-Approval_Exhibit A*. (**Note:** Each exhibit must have a different letter of the alphabet.)

Attachment G

Provider submits completed DDRS Service List, Re-approval Assessment and Accreditation documents to BQIS

Send documents to:

BQISReporting@fssa.in.gov

BQIS schedules a telephone call or meeting within 20 business days to review open items

- For BQIS to explain the questions that require further explanation/detail by the provider regarding the Re-approval Assessment submitted
- An email will be sent confirming the date and time of the call or meeting

Subject Line: DDRS Provider Re-Approval Meeting: [PROVIDER NAME]

Dear [CONTACT],

This email serves as a confirmation, per our [PHONE CALL OR EMAIL EXCHANGE], that we'll be meeting [AT BQIS' OFFICES OR VIA TELECONFERENCE] on **[DATE OF MEETING], at [TIME OF MEETING] Eastern** for an informal conversation about [PROVIDER NAME]'s Re-Approval Assessment.

The purpose of the meeting is for BQIS to explain any clarifying questions that require further explanation/detail by the provider. The meeting should only take about an hour. Please have a copy of your Re-Approval Assessment available for reference and note-taking. Following the meeting, the provider will be sent BQIS' questions and a request for the submission of a re-approval addendum to submit the clarifying information.

[INCLUDE FOR PHONE CONFERENCES] Please call the number below to join the phone conference.

Conference Line: 1-877-422-1931
Conference Code: 547 520 3621

Thank you for your cooperation in this process. Should you have any questions, please do not hesitate to contact me.

Regards,
Shelly

Below is information about parking/navigating through the Government Center to find us!

PARKING INFORMATION

- *Washington Street Government Garage (southwest of the public entrance to the Indiana Government Center South Building)*: Located on the corner of Washington Street and West Street, just south of Indiana Government Center South. The entrance to the garage is located on its east side, accessible via Missouri Street. Park in Garage entry #1; space is limited and only available when the legislature is not in session. (Fee required)
- *Senate Street Government Garage*: Located between New York Street and Ohio Street, with entrances on New York Street and Senate Avenue. Space is limited and only available when the legislature is not in session. (Fee required)
- *Eiteljorg/Indiana State Museum Garage*: Located at 500 West Washington Street, at the intersection of West and Washington Streets. Enter the underground garage from Washington Street. (Fee required)
- *Plaza Park:* Located at 109 South Capital Avenue, southeast corner of Maryland and Capital (just east from the Indiana Convention Center and south of the Hyatt Regency). (Fee required)
- *Street Parking:* Available along Washington Street. (Fee required)

MEETING LOCATION AT INDIANA GOVERNMENT CENTER SOUTH BUILDING
Enter the building through the public entrance (302 West Washington Street) on the **south side** of the Indiana Government Center building.

After clearing security:

- Follow the hall to the set of double doors that direct you to the Information Desk.
- Turn left through the doors, and proceed past the information desk through the set of open doors (marked West Wing)
- Take the elevators on the left to the 4th floor. Turn right out of the elevator and proceed to DDRS' offices, W453, just past the men's restroom on the right.

BQIS sends the provider a written request for information following the meeting.

Addendum request letter contains the questions clarified by BQIS during the meeting and a request for written response.

Subject Line: DDRS Provider Re-approval -- [PROVIDER NAME] Request for Information

[CONTACT],

It was a pleasure to speak with you and your staff regarding [PROVIDER NAME]'s re-approval with DDRS. As mentioned during our meeting, the re-approval process is an opportunity for providers to analyze their data and how it relates to the risk areas identified in the Provider Review Profile (PRP).

The purpose of the meeting was for the Bureau of Quality Improvement Services (BQIS) to explain any clarifying questions that require further explanation/detail by the provider on specific topics addressed in the Re-Approval Assessment. In order for your organization to receive the most appropriate re-approval term, please fully address the items contained in the attached letter in your written response.

To provide your response, please:

1. Use the same Re-Approval Assessment document you originally submitted.
2. On page 1 of the Re-Approval Assessment, enter the 'Date Addendum Submitted'.
3. For the specified question, after your original response in the Re-Approval Assessment, insert the word 'ADDENDUM' prior to typing your response.

Please email your completed document to BQISReporting@fssa.in.gov by **[10 CALENDAR DAYS BEYOND DATE OF LETTER]**.

Attached is a letter outlining the specific questions or areas needing clarification, specific instructions, and timelines. Please do not hesitate to contact me with any questions.

Regards,

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

Via Electronic Mail

DATE

[CONTACT INDIVIDUAL]
[CONTACT INDIVIDUAL TITLE]
[PROVIDER NAME]
[PROVIDER ADDRESS]
[PROVIDER ADDRESS]
[PROVIDER EMAIL ADDRESS]

Re: Provider Re-Approval -- Request for Information -- Due DATE

Dear **[CONTACT INDIVIDUAL]**,

It was a pleasure talking with talking with your organization on DATE. The purpose of the meeting was for the Bureau of Quality Improvement Services (BQIS) to BQIS explaining any clarifying questions that require further explanation/detail by the provider on specific topics addressed in the Re-Approval Assessment. In order for your organization to receive the most appropriate re-approval term, please fully address the items listed below in your written response.

SECTION I – *PRP Complaints and Incidents Data*
#, page ;
-

SECTION II – *PRP Incident Processing and Abuse/Neglect/Exploitation Data*
#, page ;
-

SECTION III – *PRP Behavioral Data*
#, page ;
-

SECTION IV – *PRP Medication and Medical Data*

#, page:

-

SECTION V – ***Service Delivery & Consumer Supports***
#, page:

-

To provide your response, please:

1. Use the same Re-Approval Assessment document you originally submitted.
2. On page 1 of the Re-Approval Assessment, enter the 'Date Addendum Submitted'.
3. Add your reply to the above questions, by category, after your original response the Re-Approval Assessment.
4. Please insert the word 'ADDENDUM' prior to the additional wording.

Your response is due **DATE.** Please email your reply to BQISReporting@fssa.in.gov.

Based on your Re-Approval Assessment, and the additional information provided as a result of this request, BQIS will recommend a re-approval period of 6, 12, or 36 months. Once re-approved, your organization may continue providing services through the Division of Disability and Rehabilitative Services' (DDRS) Medicaid Home and Community Based Services waiver program to people with intellectual and developmental disabilities in Indiana.

Thank you for your commitment to the re-approval process and for providing the additional information requested. As always, please do not hesitate to contact me with any questions.

Sincerely,

Shelly Thomas
Assistant Director
Bureau of Quality Improvement Services
(317) 234-2764
Shelly.Thomas@fssa.in.gov

Provider sends response to BQIS

Using the Re-Approval Assessment originally submitted, Provider inserts the word “ADDENDUM’ and then provides responses to each question in the applicable category.

Provider Services communicates provider re-approval period and sends Provider Agreement for signature and return

- Re-Approval period will be for 6, 12 or 36 months
- Return the signed Provider Agreement to: **BQISReporting@fssa.in.gov**

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

Via Electronic Mail

DATE

CONTACT
TITLE
NAME OF ORGANIZATION
STREET ADDRESS
CITY, STATE ZIP
EMAIL ADDRESS

Re: **YEAR** Provider Re-approval Term

Dear **CONTACT**,

The Division of Disability and Rehabilitative Services (DDRS) recognizes **NAME OF ORGANIZATION**'s efforts in improving its Quality Assurance/Quality Improvement systems as explained in its assessment of data identified in its Provider Review Profile (PRP) for the time period of **DATE RANGE**.

As described in DDRS' policy and process on provider re-approvals, providers must demonstrate an identification of system deficiencies where they exist in risk categories for which the provider rated above or below the expected range. It is expected that providers analyze their data and identify processes and improvements necessary to ensure its staff, policies/procedures, and overall quality systems render safe and effective services in accordance with Individualized Support Plans, Behavioral Support Plans, other service plans, and ensure the health, safety, and welfare of their consumers. Through this process, and the submission of a Re-Approval Assessment and subsequent Addendum (when appropriate), a provider is recommended for a re-approval term of six (6), twelve (12), or thirty-six (36) months.

The decision to grant **NAME OF ORGANIZATION** a **[6 or12]-month** term was based on the provider's overall efforts to address its PRP's identified risk areas through its Re-Approval Assessment (**DATE**) and Addendum (**DATE**). A **[6 or 12]**-month re-approval term indicates the need for your organization to enhance the processes currently in place to ensure the health, welfare and safety of its consumers.

To support the designation of this **[6 or 12]**-month re-approval term, BQIS has identified the following items:

SECTION I: ***PRP Complaints and Incidents Data***

-

SECTION II: ***PRP Incident Processing and ANE Data***

-

SECTION III: ***PRP Behavioral Data***

-

SECTION IV: ***PRP Medication and Medical Data***

-

SECTION V: ***Service Delivery & Consumer Supports***

-

SECTION VI: ***Improvement Plan***

-

Approval to continue providing waiver services is contingent upon DDRS receiving your agency's:

- Signed Provider Agreement (attached to this letter) within 30 calendar days of receipt of this letter.

On or before **30 DAYS BEYOND THIS LETTER DATE**, please submit a signed Provider Agreement to BQISReporting@fssa.in.gov. Failure to submit the signed Provider Agreement by this date may result in the re-approval term being reduced. If DDRS has not received a signed Provider Agreement within 60 calendar days of the date of this letter, DDRS reserves the right to begin the termination process with your agency.

If you have questions regarding your organization's re-approval determination please contact Shelly Thomas at BQISReporting@FSSA.IN.gov.

If your organization will suffer an adverse affect [sic] due to the re-approval determination, an Administrative Review, as held by an Administrative Law Judge (per 460 IAC 6-6-5(g)), may be requested. Per 460 IAC 6-7-6(a), a provider may file a written petition for review. The submitted petition must include a copy of the re-approval letter and an explanation of fact demonstrating the provider is aggrieved or adversely affected by the action.

To exercise this option, a written petition must be submitted to Kylee Hope, Director of DDRS (Kylee Hope, Director, Division of Disability and Rehabilitative Services; 402 W. Washington Street; Indianapolis, IN 46207). If a hearing request is not filed within fifteen (15) days of the date of this letter, the re-approval term is final.

Sincerely,

Shelly Thomas
Assistant Director
Bureau of Quality Improvement Services

DIVISION OF DISABILITY AND REHABILITATIVE SERVICES
SERVICE PROVIDER AGREEMENT

State Form 55006 (6-12)
FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (DDRS)
BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES (BDDS)

The provider agrees to provide Services to recipients of DDRS only under the following criteria:

1. The provider had been approved by DDRS to provide the type of Services;
2. The provider has received authorization from DDRS to provide the specific Services;
3. Services will be performed in compliance with the provisions of this Agreement and any applicable Addenda.

Legal name of provider		
Doing business as *(If the DBA name is different from the provider name, provide documentation.)*		
Home office address *(number and street, city, state, and ZIP code)*		
Mailing address *(number and street, city, state, and ZIP code)*		
Pay To address *(number and street, city, state, and ZIP code)*		
Service location(s) *(if different from above)*		
Telephone number ( )	E-mail address	Social Security number or Federal identification number *(not both)*
Type of business *(check one)* ☐ Individual ☐ Partnership ☐ Corporation ☐ Not-for Profit		
List current Medicaid provider number, if any	List current Medicaid Waiver provider number, if known	
List current Medicare provider number, if any, and specify type (i.e. home health agency, AAA, etc.)		

Signature of authorized representative	Date *(month, day, year)*
Typed or printed name of authorized representative	Title of authorized representative

SERVICE PROVIDER AGREEMENT *(continued)*
Part of State Form 55006 (6-12)

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider of services or supplies to recipients of DDRS, and as a condition of enrollment, Provider agrees:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration (FSSA).
2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program including the Medicaid Waiver Program, as they may be amended from time to time.
3. To comply with all DDRS policies available online at http://www.in.gov/fssa/ddrs/3340.htm.
4. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana's Medicaid Waiver program, or any rule or regulation promulgated pursuant thereto.
5. To notify FSSA or its agent within ten (10) calendar days of any change in the status of Provider's license, certification or permit to provide its services to the public in the State of Indiana.
6. To provide Medicaid and/or Medicaid Waiver-covered services and/or supplies for which federal financial participation is available for Medicaid Waiver recipients pursuant to all applicable federal and state statutes and regulations.
7. To strictly observe the Health Insurance Portability and Accountability Act (HIPAA).
8. To release information about Medicaid recipients only to the FSSA, its agent, or a Medicaid Waiver recipient's case manager, and only when in connection with:
   a. Providing services for recipients; and
   b. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered services.
9. To timely respond to request for data for the Day and Employment Services Outcome System from the Indiana Institute on Disability and Community of Indiana University ("Institute"), by May 31 of each year or as directed by the Institute, as well as all other data collection efforts by the State or its assigned parties.
10. To recognize that the eligibility of recipients shall be determined solely by Bureau of Developmental Disabilities service coordinators or Vocational Rehabilitation Services Counselors. The Provider shall not provide any service(s) to an individual pursuant to this Agreement unless Bureau of Developmental Disabilities service coordinators or Vocational Rehabilitation Services counselors have determined that the individual is eligible for such services.
11. To submit any and all accreditation survey reports for those services requiring accreditation to BDDS Provider Relations.
    a. As applicable, a Provider must provide BDDS Provider Relations with the following:
       i. Intent to survey or the application for accreditation
       ii. Proof of accreditation decision
       iii. Survey findings, including any Quality Improvement Programs, or any other quality improvement actions, corrective action plans, etc.
       iv. Copy of the Annual Conformance to Quality Report, or similar report.
    b. Should the Provider's certification be terminated, Provider shall notify the Bureau of Developmental Disabilities Services immediately.
12. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (e.g. hospital, ICF-MR, nursing home) or a government agency with a contract that meets the requirements described in paragraph 8 of this agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered services pursuant to this agreement.
13. To maintain a written contract with all subcontractors. Regardless of subcontracts, the Provider shall remain responsible for the proper performance of all activities under this Agreement.
14. To comply, if a hospital, nursing facility, provider of home health care and personal care services hospice or HMO, with advance directives requirements as required by 42 Code of Federal Regulations, part 489, subpart I, and 417.436.
15. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, the Medicaid Waiver Programs Provider Manual, as amended from time to time, as well as all provider notices and updates. Any amendments to the Indiana Health Coverage Programs Provider Manual, the Medicaid Waiver Program, as well as provider notices and updates communicated to Provider shall be binding as of adoption by FSSA.
16. To submit timely billing on Medicaid approved claim forms, as outlined in the Medicaid Programs Provider Manual, in an amount specified in the written contract.
17. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact will be prosecuted under the applicable Federal and/or State law.
18. To submit claim(s) for Medicaid reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.
19. To submit claim(s) for Medicaid reimbursement utilizing the appropriate claims forms and codes as specified in the Medicaid Programs Provider Manual, bulletins, and notices.
20. To submit claims that can be documented by Provider as being strictly for:
    a. those services and/or supplies specified in the Notice of Action;
    b. those services and/or supplies actually provided to the recipient in whose name the claim is being made; and
    c. any other compensation that the Provider is legally entitled to receive.

21. To accept as payment in full the amounts determined by FSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid covered services provided to Medicaid Waiver recipients. Provider agrees not to bill recipients or any member of a recipient's family, for any additional charge for Medicaid and/or Medicaid waiver covered services, excluding any co-payment permitted by law.
22. To refund within fifteen (15) days of receipt, to FSSA or its fiscal agent any duplicate or erroneous payment received.
23. To make repayments to FSSA or its fiscal agent, or arrange to have future payments from the Medicaid or Medicaid Waiver programs withheld, within sixty (60) days of receipt of notice from FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.
24. To pay interest on overpayments in accordance with IC 12-15-13-3, IC 12-15-21-3, IC 12-15-23-3.
25. To make full reimbursement to FSSA or its fiscal agent of any federal disallowance incurred by FSSA when such disallowance relates to payments previously made to Provider under the Medicaid Program.
26. To fully cooperate with federal and state officials and their agents as their agents as they conduct periodic inspections, reviews and audits, including those conducted or authorized by BQIS.
27. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid or Medicaid waiver payments made to Provider, to assure the proper administration of the Medicaid and Medicaid Waiver programs and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in the "Provider Requirements" Section of the Waiver Provider Manual and shall include, without being limited to, the following:
    a. Medical records as specified by Section 1902(a)(27) of Title XIX of the Social Security Act and any amendments thereto;
    b. records of all treatments, drugs, services and/or supplies for which vendor payments have been made, or are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drug, services and/or supplies;
    c. any records determined by FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program;
    d. documentation in each recipient's record that will enable the FSSA or its agent to verify that each charge is due and proper;
    e. financial records maintained in the standard, specified form;
    f. all other records as may be found necessary by the FSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA.
28. To cease any conduct that FSSA determines to be detrimental to the Medicaid or Medicaid Waiver programs.
29. To promptly correct deficiencies in Provider's operations upon request of FSSA or its fiscal agent.
30. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    a. The petitioner is a person to whom the order is specifically directed;
    b. The petitioner is aggrieved or adversely affected by the order; and
    c. The petitioner is entitled to review under the law.
31. Provider must file a statement of issues within the time limits below, setting out in detail:
    a. The specific findings, actions, or determinations of FSSA from which Provider is appealing;
    b. With respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.
32. Time limits for filing an appeal and the statement of the issues are as follows:
    a. The provider must file an appeal of determination that an overpayment has occurred and the statement of issues within sixty (60) days of receipt of FSSA's determination.
    b. All appeals of actions not described in (a) must be filed within fifteen (15) days of receipt of FSSA's determination. The statement of issues must be filed within forty-five (45) days of receipt of FSSA's determination.
33. To cooperate with FSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
34. To comply with civil rights requirements as mandated by federal and state statutes and regulations by ensuring that no person shall on the basis of race, color, national origin, ancestry, disability, age, sex, or religion be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the provision of a Medicaid service.
35. To comply with *42 Code of Federal Regulations, part 455, subpart B* pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to FSSA/DDRS and its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to," "mail to," or home office), federal tax identification number(s), or change in the provider's direct or indirect ownership interest or controlling interest. Pursuant to 42 Code of Federal Regulations, part 455.104(c), FSSA must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
36. To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and document set out in this Agreement and to update this information as it may be necessary.
37. That subject to item 36, this Agreement shall be effective as the date set out in the provider enrollment notification letter.
38. If the provider provides direct care services, to provide waiver services solely as authorized in the recipient's Plan of Care / Cost Comparison Budget prepared by the recipient's case manager and as the services are defined in the Medicaid Waiver Provider Manual and the appropriate waiver.
39. To provide at least sixty (60) days written notice to the recipient and/or recipient's legal representative, the recipient's case manager, if applicable and the BDDS Service Coordinator before terminating services to a recipient.
    a. If the provider is providing direct services, prior to terminating services, the Provider shall participate in an Individualized Support Team meeting to coordinate the transfer of services to a new provider.

b. The Provider agrees to continue serving the recipient until a new provider providing similar services is in place, unless written permission has been received from the State's Medicaid Waiver Specialist authorizing the provider to cease providing services before a new provider begins providing services.

40. To provide at least sixty (60) days notice to DDRS when an individual is transitioning from one (1) service provider to an alternate service provider. This includes any change in provider for any reason.
41. To provide at least sixty (60) days notice to BDDS Provider Relations before DDRS will approve any sale, including the sale of assets, where an individual's services or service provider may be affected.
42. To report any incidents (including suspected abuse, neglect or exploitation) as outlined in the DDRS Incident Reporting and Management Policy.
43. That this Agreement may be terminated as follows:
    a. By FSSA or its fiscal agent immediately for Provider's breach of any provision of this Agreement;
    b. By FSSA or its fiscal agent, or by Provider, without cause upon sixty (60) days written notice.
44. That this Agreement, upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN. ALL PREVIOUS PROVIDER AGREEMENTS ARE HEREBY RENDERED NULL AND VOID.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF NOT MORE THAN FIVE (5) YEARS OR BOTH.

PROVIDER-AUTHORIZED SIGNATURE		
The owner or an authorized officer of the business entity must complete this section. Failure to complete this section will result in an automatic denial of agreement.		
I certify, under penalty of law that the information state in this DDRS Service Provider Agreement is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified; I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each education institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Medicaid Waiver Program. All providers are required to adhere to the Indiana Administrative Code 460 IAC 6 in addition to all policies and procedures released by FSSA, DDRS and BDDS.		
Doing Business As (DBA) name of provider		Tax identification number
Signature of officer		Date *(month, day, year)*
Printed name of officer	Title	Telephone number ( )

Signature of Director of Division of Disability and Rehabilitative Services	Date *(month, day, year)*

Letter from BDDS outlining moratorium on new consumers for 90 days

If re-approval is for a 6 month time period, the re-approval is probationary and a 90 day moratorium on new consumers is initiated.

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

Via Electronic & Certified Mail

DATE

[CONTACT INDIVIDUAL]
[CONTACT INDIVIDUAL TITLE]
[PROVIDER NAME]
[PROVIDER ADDRESS]
[PROVIDER ADDRESS]
[PROVIDER EMAIL ADDRESS]

Re: Moratorium on New Admissions for Waiver Services – Effective {DATE}

Dear **[CONTACT INDIVIDUAL]**,

At the conclusion of the re-approval process, [PROVIDER NAME] was granted a probationary re-approval period by Provider Services. This re-approval term applies to services offered through the Division of Disability and Rehabilitative Services' (DDRS) Medicaid Home and Community Based Services (HCBS) waiver programs.

During this six-moth re-approval period, it is recommended that [PROVIDER NAME] focus on system (policy, procedure and protocol) improvements as addressed in the letter dated [RE-APPROVAL LETER DATE]. Given your organization's probationary re-approval status, the Bureau of Developmental Disabilities Services (BDDS) is issuing a ninety (90) day suspension of new consumers (authority granted under IC 12 11 1.1 11 (c) (3)). This suspension applies to any new consumer requesting services through DDRS' Medicaid HCBS waiver programs. This suspension will be in effect starting **[START DATE] and will end on [END DATE]**.

A provider may request an administrative hearing regarding this action (IC 12-11-1.1-11(b)). To pursue this option, a written petition must be submitted to the Director of DDRS:

Kylee Hope, Director
Division of Disability and Rehabilitative Services
402 West Washington Street, Room W453
Indianapolis, IN 46207

The submitted petition must include a copy of the moratorium letter and an explanation of fact demonstrating the provider is aggrieved or adversely affected by the action. If a hearing request is not filed within fifteen (15) days of the date of this letter, the 90 day moratorium regarding new admissions is final.

Should you have any questions, please contact Shelly Thomas at (317) 234-2764 or Shelly.Thomas@fssa.in.gov.

Sincerely,

Cathy Robinson
Director, Bureau of Developmental Disabilities Services

cc: Shelly Thomas, Assistant Director, Bureau of Quality Improvement Services

TEMPLATE_Moratorium Notice_08.11.2016

How to best communicate your findings

Data Analysis - Example Response: *"Of the 43 medication errors documented in the last year, 32 were attributed to three specific consumers. 25 of the medication errors took place when the individual was with family or other provider and not receiving services from our staff. Of the 8 remaining medication errors, it was determined that staff error was the cause and in each instance staff was retrained according to company policy before the staff member was allowed to pass medication again."*

Training - How does your organization ensure continued competency? (New hire, annual, between annual training, based on error rate, etc.)

Management - How is management oversight used to ensure compliance? (Forms, meetings, site visits, frequency, etc.)

Helpful Tips on Submission of Documents and Process Flow:

- Providers submit the Accreditation Documentation, DDRS Service List, and Re-approval Assessment as properly labeled, separate documents attached to one email. The email is sent to BQISReporting@fssa.in.gov.

- If the provider wishes to attach supporting information (training schedules, forms used in the organization, etc.), attachments may be added to the email as separate documents. Please clearly label each document as an Exhibit and reference with the Exhibit letter within the Re-approval Assessment.

- BQIS will review the documentation and contact the provider to schedule a telephone call or a meeting. The purpose of the meeting is for BQIS to explain any clarifying questions that require further explanation/detail by the provider.

Helpful Tips on Submission of Documents and Process Flow (cont.):

- Should BQIS request additional written information, please use the Re-approval Assessment document originally submitted and insert the requested information in the appropriate location in the corresponding category. Please insert the word 'ADDENDUM' prior to the additional wording. It is best to not delete the original wording and simply insert the requested information.

When in doubt….ask for guidance.

Questions

Resources

Webinar PowerPoint presentation and related documents will be available on DDRS' Provider Services webpage: http://www.in.gov/fssa/ddrs/2644.htm

Questions????:

Shelly Thomas, Assistant Director
Bureau of Quality Improvement Services
317.234.2764
Shelly.Thomas@fssa.in.gov